CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULHPL	LE CON	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		00		COMPLETED	
		155254	B. WIN	G			06/15/2	011	
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET AI	DDRESS, CITY, STATE, ZIP CODE	•		
NAME OF F	ROVIDER OR SUPPLIER			5430	30 WE	EST U.S. 40			
		ATION CONVALESCENT CENTER			EENI	FIELD, IN46140			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DEFICIENCY)		DATE	
F0000									
F0000	This visit was for Complaint IN000 Complaint IN000 Federal/state defi allegations are cit F282, and F323. Survey dates: Jun Facility number: Provider number: AIM number: 10 Survey team: Ba Census bed type: SNF/NF: 46 Total: 46 Census payor typ Medicare: 3 Medicaid: 37 Other: 6 Total: 46 Sample: 4 These deficiencies	the Investigation of 091349. 091349 Substantiated. (ciencies related to the ted at F224, F225, F226, ne 14 and 15, 2011 000157 155254 00274720 orbara Gray RN	FO	000		This plan of correction is to as Sugar Creek Rehabilitation Convalescent Center's credit allegation of compliance. Submission of the plan of correction does not constitute an admission by SCreek Rehabilitation Convalescent Centers or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the proof nursing care and other services in the facility. Nor of this submission constitute are agreement or admission of the survey allegations.	on ble dis	DATE	
									
	Quality review co	omplete 6/22/11 by							
I A BOR ATOR	V DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN.	ATIIDE			TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11

Facility ID:

000157

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION 00	ľ	OATE SURVEY OMPLETED
		155254	A. BUILDING B. WING		06.	/15/2011
	PROVIDER OR SUPPLIER CREEK REHABILITA	ATION CONVALESCENT CENTER	543	EET ADDRESS, CITY, STATE, Z O WEST U.S. 40 EENFIELD, IN46140	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) N.	ID PREFI TAG	CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F0224 SS=D	written policies and mistreatment, negl and misappropriati Based on observarecord review, the services were proprevent neglect direction to transfit Stand-Up lift instead deficient practices sampled for transfit Resident #A. Findings include: Resident #A's received for the services were proprevent neglect direction to transfit Stand-Up lift instead deficient practices sampled for transfit Resident #A's received for the services were proprevent neglect direction to transfit Stand-Up lift instead deficient practices sampled for transfit Resident #A's received for the services were propreted for transfit sampled for transfit Resident #A's received for the services were propreted for the service	cord was reviewed on	F0224	It is the practice of Rehabilitation Co Center to develop policies and proceprohibit mistreatm and abuse of resimisappropriation facility does not usexual, physical area abuse, corporal prinvoluntary seclus Aris being transferappropriate lift de Arian been assessed services to furthe there is no emotionare a result of being the stand up lifting addition her attens has evaluated her are no physical in in using the stand As indicated in the C.N.A. #1 is no look in the facility. C.N. no longer employ facility.II. Reside mechanical lift descreened to ensultant appropriate lift descreened to descreened	envalescent of and implement edures that ment, neglect, idents and of property. The use verbal, and mental counishment and sion. I. Resident erred using the evice. Resident ersed by social er ensure that conal distress as transferred with g device. In ading physician er to ensure there injuries involved dup lift device. The survey report onger employed N.A. #2 is also wed at the ents who utilize evices have been are that the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155254 06/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5430 WEST U.S. 40 SUGAR CREEK REHABILITATION CONVALESCENT CENTER GREENFIELD, IN46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE cognitively intact, she required extensive utilized. Care plans and C.N.A. assignment sheets were also assistance of two persons for transfer, she reviewed to ensure that they had limited functional range of motion in address which lift device is to be her upper and lower extremities, she had utilized.III. The facility has a policy in place regarding abuse occasional pain rated 6 on a 1 to 10 pain prevention. Staff have been scale, she received routine and as needed re-educated on this policy. This pain medication, and she did not walk. re-education stressed the importance of following the A quarterly nursing assessment for resident's plan of care and reporting any abuse concerns to Resident #A, dated 4/16/11, indicated the Admnistrator immediately. Resident #A had extremity contractures Additional systemic changes are and edema, she required two person being described below.IV. The assistance, she required a mechanical lift Director of Nursing or her designee is conducting random for transfers, and she was non-weight staff interviews regarding abuse bearing. prevention. A sample of five staff members are being interviewed weekly to ensure understanding A care plan for Resident #A, dated of the definition of abuse, the 4/19/11, indicated Resident #A was facility's abuse prevention and non-ambulatory due to contractures and reporting policy. In addition, a refused to get out of bed at times. A care random sample of 5 residents are plan for Resident #A, dated 9/30/10, being monitored weekly to ensure the appropriate lift device is being indicated Resident #A required routine used during transfers. The pain medication related to bilateral lower quality improvement audits will extremity pain. A care plan for Resident continue weekly for thirty days #A, dated 9/30/10, indicated Resident #A then monthly for six months. Results of all audits are being used a Hoyer lift for transfers. reported to the facility Quality Assurance Committee for A Resident Care Record (CNA additional recommendations Assignment Sheet), undated, for Resident when necessary. #A indicated she required transfer assist of two persons and required a Hoyer lift for transfers. Nurses notes for Resident #A indicated

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/15/2	ETED	
		1.00=0.1	B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	EST U.S. 40		
		TATION CONVALESCENT CENT	ER		FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	5/29/11 at 2:20 A.M The					
	1	ined of left calf/ankle/foot					
	1 ^	ent's left lower extremity					
	1	wice the size of her right					
	1	The skin was cool to					
		's vital signs were					
	temperature 98.4						
	_	blood pressure 138/88,					
		ration 98% room air. The					
		leg "was caught on lift					
	earlier today". N	No open areas or bruising					
	were observed b	y the writer. Notes on					
	5/29/11 at 3:00 A	A.M. indicated an order					
	was received to	send the resident to the					
	ER for evaluation	on and treatment.					
	1	remity venous Doppler for					
		ed 5/29/11 at 5:59 A.M.,					
	1	lowing: "Indication - Leg					
	1 -	Real-time ultrasound					
		e lower extremity deep					
	venous system v	vas performed from the					
		l vein to the popliteal					
	vein. All sample	ed veins demonstrate					
	normal Doppler	flow characteristics,					
	augmentation, a	nd compressibility. No					
	deep venous thro	ombosis is identified.					
	Impression - No	rmal lower extremity					
	venous Doppler.						
	An initial invest	igation provided by the					
		n 6/14/11 at 2:00 P.M.,					
	1	lowing: Brief Description					
		NA #1 asked CNA #2 to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	or connection	155254	1	ILDING	00	06/15/2	
			B. WI		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	EST U.S. 40		
		ATION CONVALESCENT CENT	ER		FIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG		ging Resident #A. CNA	+	IAG	,		DAIL
		he Stand-Up lift rather					
	1 1	resident back to bed with					
		esident #A was fearful					
	<u>-</u>	ne wanted to be put down					
		. The CNA assignment					
	indicated Resider	C					
		Hoyer lift. Resident #A					
	did not bear weigh	-					
	communicated to						
		9/11, she should not tell					
		I-Up lift was used instead					
	*	Type of Injury - No					
	l ,	mmediate Action Taken -					
	l -	a physical assessment					
		family and physician					
	were notified. A						
	conducted with F	Resident #A. Interviews					
	with other reside	nts and staff were being					
	initiated as part of	of the investigation at this					
	time. Preventive	Measures Taken - CNA					
	#2 had been susp	ended pending					
	investigation.						
	A timeline invest	igation regarding an					
	incident that occi	urred on 5/28/11,					
	^	Administrator on 6/14/11					
	at 2:00 P.M., ind	icated the following:					
		the Administrator on					
		ximately 11:00 A.M., of					
		occurred on 5/28/11, near					
	the end of her shi	ift. CNA #2 indicated					
		or her assistance in					
	changing Resider	nt #A. CNA #2 indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254		ĺ	ILDING	NSTRUCTION 00	(X3) DATE COMP 06/15/2	LETED	
	PROVIDER OR SUPPLIEI	Ⅱ : TATION CONVALESCENT CENTE		STREET A	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40 FIELD, IN46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	she was assisting #A became fearf she wanted to be legs hurt. CNA was fearful using injured in any w they changed Reback in her chair meal the next dastated to CNA # anybody they us because they we they would both Administrator mat 10:00 A.M. The determination CNA #1 did in figresident #A] are knowledge it was lit was believed and felt it more of Stand-Up lift. A follow-up involved Administrator or indicated the follinvestigation it was aware of the used in assisting the Hoyer lift as assignment sheet terminated from 6/2/11 for failing	g CNA #1 and Resident ful and was crying out that a put down and that her #2 indicated Resident #A g the lift but was not ay. CNA #2 indicated esident #A and put her as During the breakfast y on 5/29/11, CNA #1 2 she should not tell ed the Stand-Up lift, are not supposed to and get in trouble. The est with CNA #1 on 6/2/11 The Administrator made in based on the events, act use the wrong lift on and that she did have is the wrong type of lift. CNA #1 was in a hurry convenient to use the estigation provided by the convenient to use the convenient to use the Resident #A, which was noted on the CNA					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		155254	B. WIN			06/15/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	DDRESS, CITY, STATE, ZIP CODE	-	
CLICAD		TATION CONVALENCE IT CENT	ГО	1	EST U.S. 40		
		TATION CONVALESCENT CENTI		<u> </u>	FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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IAG	REGULATORT OR	LECTIDENTIFTING INFORMATION)	+	IAG			DATE
	Dogidant #A was	s observed lying in bed on					
		ne head of her bed raised :20 A.M. During					
		time, Resident #A's					
		r. Resident #A's bilateral					
	1 ^						
	1 -	cted and she could not out when requested to.					
	1 ~	ea appeared larger than the					
		eing contracted at the					
		appear edematous.					
		not have any hand esident #A indicated she					
		the date but remembered					
	I -	d by CNA #1 and CNA #2					
		Stand-Up lift. Resident					
		e was unable to stand and					
	_	sident #A indicated her					
		ful during the transfer and					
		be lowered off the lift.					
		icated she was lowered					
		esident #A indicated she					
		if her leg got caught on					
	, , ,	the transfer, only that she					
		egs. Resident #A denied					
		the interview. Resident					
		e did not fall during the					
		nt #A indicated she had					
	· -	with the Stand-Up lift one					
	time.						
		t policy and procedure for					
	1	novement of residents					
	indicated the fol	lowing: "Policy					

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l	OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	Ĭ .	LDING	00	COMPL 06/15/2	ETED
	PROVIDER OR SUPPLIER	IL	1	STREET A	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40 FIELD, IN46140	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and well-being o to promote qualit appropriate techr and move resider and Implementat dignity, comfort will be incorpora decisions regardi moving of reside responsible for d trained in the use belts, lateral boar lifting devices	irect resident care will be of manual (gait/transfer rds) and mechanical					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUILDING B. WING	00	COMP: 06/15/2	LETED
	PROVIDER OR SUPPLIER	ATION CONVALESCENT CENTE	STREET A 5430 W	ADDRESS, CITY, STATE, ZIP CO /EST U.S. 40 NFIELD, IN46140	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	EECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPLETED							
		155254	A. BUILDIN B. WING	NG		06/15/20	011
	PROVIDER OR SUPPLIER CREEK REHABILITA	I ATION CONVALESCENT CENTEI	S1 54	430 WE	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40 FIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
F0225 SS=D	have been found gor mistreating reside have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must enviolations involving abuse, including in and misappropriation reported immediate the facility and to with State law through (including to the Stagency). The facility must he alleged violations and must prevent the investigation is The results of all in reported to the addrepresentative and accordance with State survey and of working days of the violation is verified	nvestigations must be ministrator or his designated I to other officials in tate law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					
	record review, the an allegation of n immediately to the	en. ation, interview and e facility failed to ensure neglect was reported ne Administrator for 1 of wed related to transfer in	F022:	5	It is the practice of Sugar Cre Rehabilitation Convalescent Center to ensure that all alleg violations involving mistreatm neglect, or abuse, including injuries of unknown source an	ged nent,	07/01/2011

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTER	R	1	IFIELD, IN46140		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a sample of 4. (1	Resident #A) When a			misappropriation of resident		
	CNA became aw	are her coworker chose			property are reported immed		
	to use the incorre	ect lift to transfer			to the Administrator of the factors and to other officials in	CIIILY	
	Resident #A, she	e did not report the			accordance with state law		
	allegation imme	_			through the established		
	"	as not notified within 24			procedures including to the s	state	
	hours.	as not notified within 2.			survey and certification agen		
	nours.				Resident A is being transfer		
	Findings include				using the appropriate lift dev Resident A has been assess		
	Findings include	•			social services to further ens		
	1 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				that there is no emotional dis		
	l ′	s record was reviewed on			as a result of being transferre	ed	
		A.M. Diagnoses			with the standup lifting device		
	included, but we	re not limited to, chronic			addition her attending physic		
	pain, osteoarthri	tis, peripheral neuropathy,			has evaluated her to ensure		
	morbid obesity,	non-ambulatory, and			are no physical injuries invol- with using the standup lift de		
	anxiety.				As indicated in the survey re		
					CNA #1 is no longer employe	-	
	Resident #A's au	arterly Minimum Data			the facility. CNA #2 also is n		
	_	lated 4/21/11, indicated			longer employed at the facilit		
		as understood and had the			Residents who utilize mecha		
		tand others, she was			lift devices have been screer to ensure that the appropriat		
	_	t, she required extensive			device is being utilized. Care		
	1 -	•			plans and CNA assignment		
	1	ersons for transfer, she			sheets were also reviewed to		
		tional range of motion in			ensure that they address wh		
		wer extremities, she had	1		lift device is to be utilized. III.	ıne	
	_	rated 6 on a 1 to 10 pain			facility has a policy in place regarding abuse prevention.	Staff	
	1	ed routine and as needed			have been re-educated on the		
	pain medication,	and she did not walk.			policy. This re-education		
					stressed the importance of		
	A quarterly nurs	ing assessment for			following the resident's plan		
	Resident #A dated 4/16/11, indicated				care and reporting any abuse		
		extremity contractures			concerns to the Administrato immediately. Additional syst		
		required two persons	1		changes are being implemen		
	1	equired a mechanical lift			through our quality improven		
	assistance, site it	quired a meenamear mit			J 4 3 1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
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		1	D. WII.		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8			EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTER	R	1	IFIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES	1	ID			(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	for transfers and	d she was non-weight			program as described below	. IV.	
	bearing.	a bite was non wergit			The Director of Nursing or he		
	ocuring.				designee is conducting rando		
	A care plan for F	Resident #A dated			staff interviews regarding abo		
	1 -	ed Resident #A was			prevention. A sample of 5 st members are being interview		
	1				weekly to ensure understand		
	1	due to contractures and			of the definition of abuse, the	-	
		at of bed at times. A care			facility's abuse prevention ar		
	1 -	t #A dated 9/30/10,			reporting policy. In addition,		
		ent #A required routine			random sample of 5 resident being monitored weekly to e		
	1 ^	related to bilateral lower			the appropriate lift device is I		
	1 * *	A care plan for Resident			used during transfers. These		
		0, indicated Resident #A			quality improvement audits w		
	used a Hoyer lift	t for transfers.			continue weekly for 30 days		
					monthly for 6 months. Resul all audits are being reported		
	A Resident Care	Record (CNA		the facility Quality Assurance			
	Assignment She	et), undated, for Resident			Committee for additional		
	#A indicated she	required transfer assist			recommendations where		
	of two persons a	nd required a Hoyer lift			necessary.		
	for transfers.						
	Nurses notes for	Resident #A indicated					
	the following:	5/29/11 at 2:20 A.M					
	The resident con						
		ain. The writer found the					
	1	wer extremity to appear					
	1	her right lower extremity.					
		ol to touch. Resident's					
		temperature 98.4, heart					
	1	-					
	1 -	ons 20, blood pressure					
	1	gen saturation 98% room					
		t said her leg "was caught					
	1	lay." No open areas or					
	1 -	served by the writer.	1				
	5/29/11 at 3:00 A	A.M Received order to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
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			_		ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	PROVIDER OR SUPPLIER	-		5430 W	/EST U.S. 40		
	CREEK REHABILIT	ATION CONVALESCENT CENTI	ER	GREEN	NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		to the ER for evaluation					
	and treatment.						
	A laft lawar avtra	emity venous Doppler for					
		ed 5/29/11 at 5:59 A.M.,					
		owing: "Indication - Leg					
		Real-time ultrasound					
	1 -	lower extremity deep					
		as performed from the					
	I -	vein to the popliteal					
		ed veins demonstrate					
	_	flow characteristics,					
	1	nd compressibility. No					
	1 -	ombosis is identified.					
	_						
	_	mal lower extremity					
	venous Doppler.'						
	An initial investi	gation provided by the					
	Administrator on	6/14/11 at 2:00 P.M.,					
	indicated the foll	owing: Brief Description					
	of Incident - CN	A #1 asked CNA #2 to					
	assist her in chan	ging Resident #A. CNA					
	#1 opted to use the	he Stand-Up lift rather					
	than putting her l	back to bed with the					
	Hoyer lift. Resid	lent #A was fearful and					
	crying out she wa	anted to be put down and					
	her legs hurt. Th	e CNA assignment					
	indicates Resider	nt #A was to be					
	transferred by a I	Hoyer lift. Resident #A					
	does not bear we	ight. CNA #1					
	communicated to	CNA #2 during					
	breakfast on 5/29	9/11, she should not tell					
	anyone the Stand	l-Up lift was used instead					
	of the Hoyer lift.	Type of Injury - No					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11 Facility ID:

000157

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPI 06/15/2	LETED	
		100204	B. WIN			00/15/2	.011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EST U.S. 40		
SUGAR	CREEK REHABILITA	ATION CONVALESCENT CENT	ER	1	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		mmediate Action Taken -		IAU			DATE
	l ~	a physical assessment					
		family and physician					
	were notified. A						
		Resident #A. Interviews					
		nts and staff are being					
		of the investigation at this					
		Measures Taken - CNA					
	#2 has been susp						
	investigation.						
	A timeline invest	igation regarding an					
	incident that occu	urred on 5/28/11,					
	provided by the A	Administrator on 6/14/11					
	at 2:00 P.M., ind	icated the following:					
	CNA #2 notified	the Administrator on					
		ximately 11:00 A.M., of					
		occurred on 5/28/11, near					
		ift. CNA #2 indicated					
		or her assistance in					
		nt #A. CNA #2 indicated					
	l	CNA #1 and Resident					
		ul and was crying out that					
		put down and that her					
	-	#2 indicated Resident #A					
		g the lift but was not ay. CNA #2 indicated					
	'	sident #A and put her					
	-	. During breakfast meal					
		5/29/11, CNA #1 stated to					
	l -	ald not tell anybody they					
		p lift because they were					
		and they would both get					
		Administrator met with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155254		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/15/2	LETED		
	PROVIDER OR SUPPLIER	 - ATION CONVALESCENT CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	CNA #1 on 6/2/1 Administrator meased on the every use the wrong lift she did have known type of lift. It was in a hurry and fer use the Stand-Up. A follow-up inverse Administrator or indicated the follow-use tigation it is was aware of the used in assisting the Hoyer lift as assignment sheet terminated from 6/2/11 for failing procedures in procedures in procedures in procedures at this speech was clear legs were contracted to be knee but did not	1 at 10:00 A.M. The ade the determination onts, CNA #1 did in fact of the on Resident #A and that wledge it was the wrong as believed CNA #1 was at it it more convenient to of lift. Sestigation provided by the a 6/14/11 at 2:00 P.M., owing: Upon a believed that CNA #1 appropriate lift to be Resident #A, which was noted on the CNA at CNA #1 was ther employment on a to follow proper oviding resident care. Observed lying in bed on the head of her bed raised 20 A.M. During time, Resident #A's bilateral carded and she could not out when requested to a appeared larger than the ening contracted at the appear edematous.		TAG	DEFICIENCY)	ALE	DATE	
	contractures. Re	not have any hand sident #A indicated she he date but remembered						

000157

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155254	B. WIN	NG		06/15/2	011
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP CODE		
OLIOAD		FATION CONTAINED CENT CENT	-D		EST U.S. 40		
	_	TATION CONVALESCENT CENT	EK	<u> </u>	FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	 	d by CNA #1 and CNA #2	-	IAG	,		DATE
	1 ~	Stand-Up lift. Resident					
	1	e was unable to stand and					
		sident #A indicated her					
	1	ful during the transfer and					
	1	be lowered off the lift.					
	1 ^	icated she was lowered					
		esident #A indicated she					
		if her leg got caught on					
	1	the transfer, only that she					
	' ' '	egs. Resident #A denied					
	1 ^	the interview. Resident					
		e did not fall during the					
		nt #A indicated she had					
	only been lifted	with the Stand-Up lift one					
	time.	•					
	The most curren	t policy and procedure for					
	safe lifting and r	novement of residents					
	indicated the fol	lowing: Policy Statement					
	- In order to pro	tect the safety and					
	well-being of sta	aff and residents, and to					
	1 ^ *	care, this facility uses					
	1 ** *	niques and devices to lift					
		ents. Policy Interpretation					
	1 ^	tion - 1.) Resident safety,					
	1	and medical condition					
	1	ated into goals and					
	1	ing the safe lifting and					
	moving of reside						
	1 -	lirect resident care will be					
	1	e of manual (gait/transfer					
	1	ards) and mechanical					
	lifting devices						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/15/2011				
	PROVIDER OR SUPPLIER	ATION CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40 GREENFIELD, IN46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	This federal tag is IN00091349. 3.1-28(c)	relates to Complaint						
F0226 SS=D	written policies an mistreatment, neg and misappropriat Based on intervior record review, the its policy was for reporting of an a	levelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. ew, observation, and he facility failed to ensure llowed related to timely hallegation of neglect to r for 1 of 4 residents	F0226	It is the practice of Sugar Cre Rehabilitation Convalescent Center to develop and imple policies and procedures that prohibit mistreatment, negled and abuse of residents and	ment			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155254	B. WIN	NG		06/15/2	011
NAME OF I	PROVIDER OR SUPPLIEI	·	•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
TVIIVIL OI	ROVIDER OR SOLITEIE				EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENT	ER	GREEN	FIELD, IN46140		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed related	to transfer in a sample of			misappropriation of property	. The	
	4. (Resident #A) When a CNA became			facility does not use verbal, sexual, physical, and mental		
	aware her cowor	ker chose to use the			abuse, corporal punishment,		
	incorrect lift to t	ransfer Resident #A, she			involuntary seclusion. I. Res		
	did not report the	e allegation immediately,			A is being transferred using t		
	_	trator was not notified			appropriate lift device. Resid	dent	
	within 24 hours.				A has been assessed by soo		
	771dilli 27 110dis.				services to further ensure that		
	Findings in al. 1.				there is no emotional distres a result of being transferred		
	Findings include	2 .			the standup lifting device. In		
					addition her attending physic		
	1	ost current policy and			has evaluated her to ensure		
	procedure on Pro	eventing Resident Abuse			are no physical injuries invol	ved	
	provided by the	Administrator on 6/14/11			with using the standup lift de		
	at 12:02 P.M., ir	ndicated the following:			As indicated in the survey re		
	"Policy Interpret	tation and			CNA #1 is no longer employed		
		4.) Employees, facility			the facility. CNA #2 also is r longer employed at the facili		
	_	or Attending Physicians			Residents who utilize mecha		
		ly report any suspected			lift devices have been screen		
		ts of abuse to any			to ensure that the appropriat	e lift	
					device is being utilized. Care	е	
	_	d, Manager on Duty,			plans and CNA assignment		
	Director of Nurs				sheets were also reviewed to		
		In the absence of the			ensure that they address wh lift device is to be utilized. III		
		ing Services and			facility has a policy in place	. 1110	
	Administrator su	ich reports may be made			regarding abuse prevention.	Staff	
	to the Nurse Sup	pervisor of Department			have been re-educated on the	nis	
	Head on Duty. 5	.) Any individual			policy. This re-education		
	observing an inc	ident of resident abuse or			stressed the importance of	of	
	suspecting reside				following the resident's plan care and reporting any abuse		
		ort such incident to the			concerns to the Administrato		
	1 - 1	Director of Nursing			immediately. Additional syst		
	Services"	2 Dioctor of Marshing			changes are being implemen	nted	
	SCIVICUS				through our quality improven		
	D :1 . // A.				program as described below		
		cord was reviewed on			The Director of Nursing or he		
	6/14/11 at 10:28	A.M. Diagnoses			designee is conducting rand	UIII	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTER	₹	I	IFIELD, IN46140		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	1	ID		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	included, but we	re not limited to, chronic			staff interviews regarding abo		
	pain, osteoarthri	tis, peripheral neuropathy,			prevention. A sample of 5 st		
	_	non-ambulatory, and			members are being interview		
	anxiety.	3,			weekly to ensure understand of the definition of abuse, the		
					facility's abuse prevention ar		
	Resident #A's au	arterly Minimum Data			reporting policy. In addition,	а	
	1	lated 4/21/11, indicated			random sample of 5 resident		
		as understood and had the			being monitored weekly to er the appropriate lift device is t		
		tand others, she was			used during transfers. These	•	
	I -	et, she required extensive			quality improvement audits w		
		ersons for transfer, she			continue weekly for 30 days		
	1				monthly for 6 months. Resul		
		tional range of motion in			all audits are being reported the facility Quality Assurance		
		wer extremities, she had			Committee for additional	·	
		rated 6 on a 1 to 10 pain			recommendations where		
	· ·	ed routine and as needed			necessary.		
	pain medication,	and she did not walk.					
	A quarterly nurs	ing assessment for					
		ed 4/16/11, indicated					
		extremity contractures					
		required 2 persons					
		equired a mechanical lift					
		I she was non-weight					
	bearing.	i she was non-weight					
	ocaring.						
	A care plan for R	Resident #A dated					
		ed Resident #A was					
	•	due to contractures and					
	1	at of bed at times. A care					
	1	t #A dated 9/30/10,					
	1 ^	-					
		nt #A required routine					
	1 ^	related to bilateral lower					
		A care plan for Resident					
	#A dated 9/30/10), indicated Resident #A					

´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155254	B. WIN	_		06/15/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CLICAD	ODEEN DELIABILIT	ATION CONVALESCENT CENT	⊏D.		EST U.S. 40		
SUGAR CREEK REHABILITATION CONVALESCENT CENT			EK	GREEN	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG			-	IAG	DEFECT.		DATE
	used a Hoyer lift	for transfers.					
	A.D. :1 . C	1.C. D. :1 4//A					
		record for Resident #A					
	^	uired transfer assist of 2					
	1 ^	ired a Hoyer lift for					
	transfers.						
	Name	Danidant #A in Biret 1					
		Resident #A indicated					
		5/29/11 at 2:20 A.M					
	The resident com	•					
	_	nin. Found by this writer					
		he size of her right lower					
	1	kin is cool to touch.					
		igns are temperature					
	l '	9, respirations 20, blood					
	_	and oxygen saturation					
		he resident said her leg					
	~	ift earlier today". No					
	_	ising were observed by					
		'11 at 3:00 A.M					
		o send the resident to the					
	ER for evaluation	n and treatment.					
		emity venous Doppler for					
		d 5/29/11 at 5:59 A.M.,					
	indicated the foll	owing: Indication - Leg					
	pain. Findings -	Real-time ultrasound					
	evaluation of the	lower extremity deep					
	venous system w	as performed from the					
	common femoral	vein to the popliteal					
	vein. All sample	d veins demonstrate					
	normal Doppler	flow characteristics,					
	augmentation, an	d compressibility. No					
	deep venous thro	mbosis is identified.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMPI 06/15/2	LETED	
	DER OR SUPPLIER EK REHABILITA	ATION CONVALESCENT CENTER	STREET 5430 '	r ADDRESS, CITY, STATE, ZIP CODE WEST U.S. 40 NFIELD, IN46140		
I	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
1 *	oression - Nor ous Doppler.	mal lower extremity				
Adrindi of I assi #1 of thar Hoy cryi her indi tran doe com brea any of tl inju Res com wer con with initi time #2 I inve	ministrator on icated the folloncident - CN. ist her in changopted to use the putting her byer lift. Residing out she walegs hurt. The icates Resident is ferred by a Histories not bear wein municated to akfast on 5/29 one the Standihe Hoyer lift. It is noted. In it ident #A had impleted. The free notified. And ducted with R in other resider iated as part one. Preventive has been suspensation.	gation provided by the 6/14/11 at 2:00 P.M., owing: Brief Description A #1 asked CNA #2 to ging Resident #A. CNA he Stand-Up lift rather tack to bed with the ent #A was fearful and anted to be put down and he CNA assignment at #A was to be Hoyer lift. Resident #A ght. CNA #1 CNA #2 during /1,1 she should not tell -Up lift was used instead Type of Injury - No hamediate Action Taken - a physical assessment family and physician interview was he				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11 Facility ID:

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<u> </u>	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/15/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	D. WII.		DDRESS, CITY, STATE, ZIP CODE		
					EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTI	ER	GREEN	FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		licated the following:		IAG			DATE
	· ·	the Administrator on					
		ximately 11:00 A.M., of					
		occurred on 5/28/11, near					
		ift. CNA #2 indicated					
		or her assistance in					
		ent #A. CNA #2 indicated					
	1 0 0	g CNA #1 and Resident					
	#A became fearf	ful and was crying out that					
	she wanted to be	e put down and that her					
	legs hurt. CNA	#2 indicated Resident #A					
	was fearful using	g the lift but was not					
	injured in any w	ay. CNA #2 indicated					
	they changed Re	sident #A and put her					
	back in her chair	. During breakfast meal					
	the next day on :	5/29/11, CNA #1 stated to					
	CNA #2 she sho	uld not tell anybody they					
	used the Stand-U	Jp lift because they were					
		and they would both get					
		Administrator met with					
		11 at 10:00 A.M. The					
		ade the determination					
		ents, CNA #1 did in fact					
		ft on Resident A and that					
		owledge it was the wrong					
	. –	as believed CNA #1 was					
	1 *	It it more convenient to					
	use the Stand-U _l	o litt.					
	A follow up in	actigation provided by the					
	_	estigation provided by the 16/14/11 at 2:00 P.M.,					
	indicated the fol	,					
		s believed that CNA #1					
	_	e appropriate lift to be					
	was await of the	appropriate intito be					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KU4U11 Facility ID:

000157

If continuation sheet Page 22 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			5430 W	/EST U.S. 40		
	SUGAR CREEK REHABILITATION CONVALESCENT CENTER		R		IFIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAU	†	<u> </u>	+	IAU			DATE
	1	Resident #A, which was					
	1 -	noted on the CNA					
	assignment shee						
	1	her employment on					
	1	g to follow proper					
	procedures in pr	oviding resident care.					
	Resident #A was	s observed lying in bed on					
	1	ne head of her bed raised					
	1	:20 A.M. During					
	1	time, Resident #A's					
	1	r. Resident #A's bilateral					
	1 ^	cted and she could not					
	1 -	out when requested to.					
	1 -	ea appeared larger than the					
	1	eing contracted at the					
	1 -	appear edematous.					
		not have any hand					
	1	esident #A indicated she					
		the date but remembered					
		l by CNA #1 and CNA #2					
	1	Stand-Up lift. Resident					
	1	was unable to stand and					
		sident #A indicated her					
		ful during the transfer and					
		be lowered off the lift.					
	_	icated she was lowered					
		esident #A indicated she					
		if her leg got caught on					
	1	the transfer, only that she					
	1	egs. Resident #A denied					
	1 -	the interview. Resident					
	1	e did not fall during the					
	1	_					
	mansier. Reside	nt #A indicated she had	1				

000157

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/15/2	LETED		
	PROVIDER OR SUPPLIER		B. WING GO/13/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40 GREENFIELD, IN46140					
SUGAR (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR Only been lifted wittime. The most current safe lifting and mindicated the following of star promote quality of appropriate technand move resider and Implementate dignity, comfort will be incorporate decisions regarding moving of reside responsible for dignary that is the use belts, lateral boar lifting devices	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) with the Stand-Up lift one a policy and procedure for novement of residents owing: Policy Statement eet the safety and ff and residents, and to care, this facility uses niques and devices to lift ints. Policy Interpretation ion - 1.) Resident safety, and medical condition ted into goals and ing the safe lifting and	ER			E	(X5) COMPLETION DATE	
F0282 SS=D	facility must be pro	ded or arranged by the ovided by qualified persons n each resident's written						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			/EST U.S. 40		
SLICAD	ODEEK DEHARII IT	TATION CONVALESCENT CENTER	5	l	NFIELD, IN46140		
	CINEER INCHABILIT	ATION CONVALESCENT CENTER	`				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on observ	ations, interview, and	F0	282	It is the practice of Sugar Cre	eek	07/01/2011
	record review, th	ne facility failed to follow			Rehabilitation Convalescent	,	
	a resident's plan	of care for transfer, in			Center to provide services by qualified persons in accordar		
	_	ferred a resident with a			with each resident's written p		
	Stand-Up lift ins	tead of a Hoyer lift, for 1			of care. I. Resident A is being		
	_	mpled for transfers.			transferred using the approp		
	Resident #A.	impieu for nansiers.			lift device. Resident A has b	een	
	Resident #A.				assessed by social services		
					further ensure that there is n		
	Findings include				emotional distress as a resul	t of	
					being transferred with the standup lifting device. In add	lition	
	Resident #A's re	cord was reviewed on			her attending physician has	altion	
	6/14/11 at 10:28	A.M. Diagnoses			evaluated her to ensure there	e are	
	included, but we	re not limited to, chronic			no physical injuries involved		
	· ·	tis, peripheral neuropathy,			using the standup lift device.		
	l ^ ·	non-ambulatory, and			indicated in the survey repor		
	l	non-amouratory, and			CNA #1 is no longer employe		
	anxiety.				the facility. CNA #2 also is n		
					longer employed at the facilit Residents who utilize mecha		
	Resident #A's qu	arterly Minimum Data			lift devices have been screer		
	Set assessment, of	dated 4/21/11, indicated			to ensure that the appropriat		
	Resident #A was	understood and had the			device is being utilized. Care		
	ability to underst	tand others, she was			plans and CNA assignment		
	· ·	et, she required extensive			sheets were also reviewed to		
	1 ~ ,	o persons for transfer, she			ensure that they address wh		
		tional range of motion in			lift device is to be utilized. III.		
		_			facility's policy regarding follo		
		wer extremities, she had			the resident's care plan has lead to be	Jeen	
	1 ^	rated 6 on a 1 to 10 pain			adequate. Nursing personne	el le	
		ed routine and as needed			have been re-educated on the		
	pain medication,	and she did not walk.			policy. Additional systemic		
					changes are being implemer		
	A quarterly nurs	ing assessment for			through our quality improven		
		ed 4/16/11, indicated			program as described below	. IV.	
	Resident #A had extremity contractures				The DON or her designee is	dito	
		required two person			conducting quality of care au A random sample of 5 reside		
	l '				are being monitored weekly		
	assistance, she re	equired a mechanical lift	l		are being morniored weekly		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155254	B. WIN			06/15/20	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EST U.S. 40		
SUGAR (CREEK REHABILIT	ATION CONVALESCENT CENTER	۲		IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		.	DATE
	for transfers, and she was non-weight bearing. A care plan for Resident #A dated				ensure the appropriate lift device is being used during transfers.		
					These quality improvement a		
					ays		
					then monthly for 6 months.		
	4/19/11, indicate	d Resident #A was			Results of all audits are being	٠ .	
	non-ambulatory due to contractures and				reported to the facility Quality	/	
	refused to get ou	t of bed at times. A care			Assurance Committee for additional recommendations		
	plan for Resident	t #A dated 9/30/10,			where necessary.		
	-	nt #A required routine			Í		
		related to bilateral lower					
	•	A care plan for Resident					
), indicated Resident #A					
	used a Hoyer lift						
	used a 110 yet 111t	Tor transfers.					
	A Resident Care	Record (CNA					
		et), undated, for Resident					
	-	required transfer assist					
		•					
	•	nd required a Hoyer lift					
	for transfers.						
	Nurses notes for	Resident #A indicated					
	the following: 5	5/29/11 at 2:20 A.M					
	The resident com	plained of left					
	calf/ankle/foot pa	ain. The left lower					
	*	und to appear twice the					
		ower extremity. The					
		touch. Resident's vital					
	signs were temperature 98.4, heart rate 69, respirations 20, blood pressure 138/88,						
	and oxygen saturation 98% room air. The resident said her leg "was caught on lift earlier today". No open areas or bruising						
	_	y this writer. 5/29/11 at					
	3:00 A.M An o	order was received to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	INSTRUCTION 00	(X3) DATE COMPL		
		155254	B. WIN			06/15/2	011
	PROVIDER OR SUPPLIER CREEK REHABILITA	ATION CONVALESCENT CENTI	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE PEST U.S. 40 IFIELD, IN46140	1	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	send the resident to the ER for evaluation and treatment.						
	A left lower extre	emity venous Doppler for					
		ed 5/29/11 at 5:59 A.M.,					
		owing: "Indication - Leg					
		Real-time ultrasound					
	evaluation of the	lower extremity deep					
	venous system w	as performed from the					
	common femoral	vein to the popliteal					
		ed veins demonstrate					
		flow characteristics,					
	-	nd compressibility. No					
	1 -	mbosis is identified.					
	_	mal lower extremity					
	venous Doppler.'	"					
	l .	gation provided by the					
		6/14/11 at 2:00 P.M.,					
		owing: Brief Description					
		A #1 asked CNA #2 to					
		ging Resident #A. CNA					
	_	he Stand-Up lift rather					
	, · ·	resident back to bed with					
	1	esident #A was fearful					
	, ,	ne wanted to be put down					
	_	. The CNA assignment					
	indicated Resider						
	l	Hoyer lift. Resident #A					
	did not bear weig						
	communicated to	•					
		9/11, she should not tell					
	l -	Stand-Up lift was used					
	instead of the Ho	yer IIIt.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155254	A. BUI	LDING	00	COMPL 06/15/2	
		155254	B. WIN			00/13/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SUGAR	CREEK REHABILIT	ATION CONVALESCENT CENTI	FR	1	'EST U.S. 40 IFIELD, IN46140		
					III ILLD, II 140 140		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
		,		_			
	A timeline regard	ling an incident that					
		/11, provided by the					
		6/14/11 at 2:00 P.M.,					
	indicated the foll	· ·					
		1 asked for her assistance					
		dent #A. CNA #2					
		s assisting CNA #1 and					
		ame fearful and was					
		ne wanted to be put down					
		hurt. CNA #2 indicated					
	_	fearful using the lift but					
		•					
	· ·	• •					
	-	_					
	-	-					
		•					
		_					
		_					
		•					
	-						
	are stand op me	•					
	A follow-up inve	stigation provided by the					
	-						
	indicated they che put her back in her breakfast meal the CNA #1 stated to tell anybody they because they were they would both Administrator meat 10:00 A.M. To the determination CNA #1 did in far [Resident #A] and knowledge it was It was believed the hurry and felt it in the Stand-Up lift. A follow-up inverse Administrator on indicated the follow-up inverse indica	the next day on 5/29/11, to CNA #2 she should not by used the Stand-Up lift the not supposed to and get in trouble. The let with CNA #1 on 6/2/11 the Administrator made in based on the events, and the wrong lift on dishe did have so the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong type of lift is the wrong type of lift. The let wrong type of lift is the wrong typ					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11 Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2)) MULTIPLE CO			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	BUILDING	00		COMPL	
		155254	B. W	VING			06/15/2	011
NAME OF F	ROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
					EST U.S. 40	_		
SUGAR (CREEK REHABILITA	ATION CONVALESCENT CE	NTER	GREEN	FIELD, IN46140	0		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEF	FICIENCY)		DATE
		appropriate lift to be						
	_	Resident #A, which was						
	-	noted on the CNA						
	assignment sheet	•						
	D 11	1 11: 11:						
		observed lying in bed on						
	•	e head of her bed raised						
	on 6/14/11 at 10:	-						
		time. Resident #A's						
	•	. Resident #A's bilateral						
	-	cted and she could not						
	_	out when requested to.						
		a appeared larger than the						
	_	eing contracted at the						
		appear edematous.						
		not have any hand						
	contractures. Re	sident #A indicated she						
	could not recall t	he date but remembered						
	being transferred	by CNA #1 and CNA #2						
	with the use of a	Stand-Up lift. Resident						
	#A indicated she	was unable to stand and						
	bear weight. Res	sident #A indicated her						
	left leg was paint	ful during the transfer and						
	she requested to 1	be lowered off the lift.						
	Resident #A indi	cated she was lowered						
	onto the bed. Re	sident #A indicated she						
	could not recall is	f her leg got caught on						
	anything during t	the transfer, only that she						
		egs. Resident #A denied						
	-	he interview. Resident						
		did not fall during the						
		nt #A indicated she had						
		with the Stand-Up lift one						
	time.							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	KU4U	11 Facility I	D: 000157	If continuation sh	eet Pa	 ge 29 of 43

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	COMPL	(X3) DATE SURVEY COMPLETED 06/15/2011	
	ROVIDER OR SUPPLIER	ATION CONVALESCENT CENTER	₹	5430 WI	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40 FIELD, IN46140			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	, and the second se	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
	The most current safe lifting and n indicated the foll - In order to prot well-being of sta promote quality appropriate techn and move resider and Implementat dignity, comfort will be incorporate decisions regarding moving of resideresponsible for d trained in the use belts, lateral boar lifting devices	a policy and procedure for novement of residents owing: Policy Statement ect the safety and ff and residents, and to care, this facility uses niques and devices to lift ints. Policy Interpretation ion - 1.) Resident safety, and medical condition ated into goals and ing the safe lifting and ints 4.) Staff irect resident care will be of manual (gait/transfer and and mechanical						
	Inis federal tag i IN00091349.	relates to Complaint						
F0323 SS=E	environment rema hazards as is poss receives adequate	nsure that the resident ins as free of accident sible; and each resident e supervision and assistance						
	record review, the transfer residents Hoyer mechanica prevent accidents	accidents. ation, interview and e facility failed to s with a Stand Up and al lift in a manner to s for 4 of 4 residents 3, #C, and #D) sampled	F03	323	It is the practice of Sugar Cre Rehabilitation Convalescent Center to ensure that the resident's environment remai as free from accident hazard is possible; and each residen receives adequate supervision	ns s as it	07/01/2011	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		155254	B. WIN			06/15/2011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				/EST U.S. 40			
SUGAR	CREEK REHABILITA	ATION CONVALESCENT CENTER	₹		IFIELD, IN46140			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	COMPLETION			
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
	for transfers.				and assistance devices to pr	event		
					accidents. I. Resident A is be	-		
	Findings include:				transferred using the approp			
	1 mamgs merade	•			lift device. Resident A has be			
	1) Posidont #A!	s record was reviewed on			assessed by social services further ensure that there is no			
	· ·				emotional distress as a resul			
	6/14/11 at 10:28				being transferred with the			
	·	re not limited to, chronic			standup lifting device. In add	dition		
		is, peripheral neuropathy,			her attending physician has			
	morbid obesity, r	non-ambulatory, and			evaluated her to ensure there			
	anxiety.				no physical injuries involved			
					using the standup lift device. indicated in the survey report			
	Resident #A's qu	arterly Minimum Data			CNA #1 is no longer employe			
	•	ated 4/21/11, indicated	the facility. CNA #2 also is no					
		as understood and had the			longer employed at the facilit	y. II.		
		and others, she was	Residents who utilize mechanical					
	-	t, she required extensive	lift devices have been screened					
		ersons for transfers, she			to ensure that the appropriate device is being utilized. Care			
	-				plans and CNA assignment	1		
		tional range of motion in			sheets were also reviewed to			
		wer extremities, she had			ensure that they address whi			
	•	ated 6 on a 1 to 10 pain			lift device is to be utilized. III.	The		
	· ·	ed routine and as needed			facility's policy on using			
	pain medication,	and she did not walk.			mechanical lifts has been reviewed and amended to in-	clude		
					the safety instructions regard			
	A quarterly nursi	ng assessment for			locking of the rear caster who	<u> </u>		
	Resident #A date	ed 4/16/11, indicated			Nursing personnel have beer	n		
	resident #A had e	extremity contractures			educated on this new policy.	IV.		
		equired 2 persons			The DON or her designee is	ماناء		
	assistance, she required a mechanical lift				conducting quality of care au A random sample of 5 reside			
	for transfer, and she was non-weight bearing.				are being monitored weekly t			
					ensure the appropriate lift de			
					is being used during transfer	S.		
	A computer Composite 4 #A 1 4 1				This audit includes making s			
	A care plan for Resident #A dated				that the rear caster wheel of			
		d Resident #A was			lift device are not locked duri			
	non-ambulatory	due to contractures and			lifting/transfer of the resident			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
		l .	D		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF I	PROVIDER OR SUPPLIEF	8			EST U.S. 40		
		TATION CONVALESCENT CENTER	₹	GREEN	IFIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	refused to get out of bed at times. A care				These quality improvement a will continue weekly for 30 da		
	1 ^	t #A dated 9/30/10,			then monthly for 6 months.	дуб	
		nt #A required routine			Results of all audits are bein	g	
	_	related to bilateral lower			reported to the facility Quality	y	
		A care plan for Resident			Assurance Committee for		
	#A dated 9/30/10), indicated Resident #A			additional recommendations where necessary.		
	used a Hoyer lift	for transfer.			where necessary.		
	A Resident Care	•					
	_	et), undated, for Resident					
	#A indicated she	required transfer assist					
	of 2 persons and	required a Hoyer lift for					
	transfer.						
	Nurses notes for	Resident #A indicated					
	the following:	5/29/11 at 2:20 A.M					
	The resident con	nplained of left					
	calf/ankle/foot p	ain. Found by this writer					
	to appear twice t	he size of her right lower					
	extremity. The s	skin is cool to touch.					
	1	signs are temperature					
		69, respirations 20, blood					
		and oxygen saturation					
	1 *	The resident said her leg					
		ift earlier today". No					
	1	uising were observed by					
	1 -	/11 at 3:00 A.M					
	Received order to send the resident to the						
	ER for evaluation and treatment.						
	EK for evaluation and treatment.						
	A left lower extremity venous Doppler for						
	Resident #A dated 5/29/11 at 5:59 A.M.,						
		lowing: Indication - Leg					
		Real-time ultrasound					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155254			LDING	nstruction 00	(X3) DATE S COMPL 06/15/2	ETED
NAME OF	PROVIDER OR SUPPLIE	<u> </u>	D . Will	STREET A	DDRESS, CITY, STATE, ZIP CODE		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENT	ER	GREEN	FIELD, IN46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	venous system venous common femoral vein. All sample normal Doppler augmentation, and deep venous through the large venous Doppler. An initial invest Administrator or indicated the folloof Incident - CN assist her in chart #1 opted to use to than putting her Hoyer lift. Residently and the legs hurt. The indicates Resident transferred by a does not bear we communicated to breakfast on 5/2 anyone that the Standard of the Hono injuries note. A follow-up inventional forms of the follow-up inventional form	igation provided by the a 6/14/11 at 2:00 P.M., lowing: Brief Description IA #1 asked CNA #2 to aging Resident #A. CNA the Stand-Up lift rather back to bed with the dent #A was fearful and anted to be put down and the CNA assignment at #A was to be Hoyer lift. Resident #A eight. CNA #1 to CNA #2 during 19/11, she should not tell Stand-Up lift was used over lift. Type of Injury -d. estigation provided by the in 6/14/11 at 2:00 P.M.,					

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Event ID: KU4U11 Facility ID:

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If continuation sheet

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	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUI	LDING	NSTRUCTION 00		(X3) DATE : COMPL 06/15/2	ETED
		100201	B. WIN		DDDEGG COMY 5=:	TE SID COST	30, 10,2	· · ·
NAME OF I	PROVIDER OR SUPPLIE	R		1	DDRESS, CITY, STA EST U.S. 40	ATE, ZIP CODE		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CEN	ITER	1	FIELD, IN46140)		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIATI ICIENCY)	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEF	ICIENCY)		DATE
		sisting Resident #A, which						
	was the Hoyer li	ift.						
	Resident #A was her back, with the on 6/14/11 at 10 interview at this speech was clear legs were contrastraighten them. Her left knee are right related to be knee but did not Resident #A did contractures. Recould not recall being transferred with the use of a #A indicated she bear weight. Releft leg was pain she requested to Resident #A indonto the bed. Recould not recall anything during had pain in her lany pain during #A indicated she transfer. Reside	s observed lying in bed on the head of her bed raised :20 A.M. During time, Resident #A's r. Resident #A's bilateral acted and she could not out when requested to be a appeared larger than the being contracted at the appear edematous. The not have any hand besident #A indicated she the date but remembered did by CNA #1 and CNA #2 a Stand-Up lift. Resident was unable to stand and besident #A indicated her aful during the transfer and be lowered off the lift. icated she was lowered besident #A indicated she if her leg got caught on the transfer, only that she egs. Resident #A denied the interview. Resident ent #A indicated she had with the Stand-Up lift one						
	2.) Resident #B	's record was reviewed on						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	KU4U11	Facility I	D: 000157	If continuation sh	eet Pa	ge 34 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155254	B. WIN			06/15/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF	8			EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTE	R	1	IFIELD, IN46140		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	6/14/11 at 12:33	P.M. Diagnoses					
	included, but we	re not limited to, left					
	hemiplegia, lowe	er extremity neuralgia,					
	chronic venostas	is changes of leg, deep					
		obesity, and seizures.					
	, can unionicosis,	ocessy, and semants.					
	Resident #B's au	arterly Minimum Data					
	1	lated 3/10/11, indicated					
	the following: R	•					
		ne was able to understand					
	others, his cogni						
		nired, he was total					
	1 -	persons for bed mobility					
	· ·	had functional limitations					
	in his upper and	lower extremities, and he					
	did not walk.						
	A quarterly nurs	ing assessment for					
	Resident #B date	ed 3/10/11, indicated he					
	required two per	son assistance and use of					
	mechanical lift.						
	A care plan for F	Resident #B dated					
	1 *	ed he used a Stand-Up lift					
	for transfers.	a ne asea a stana ep mi					
	ioi transicis.						
	A Resident Care	Record (CNA					
		•					
	Assignment Sheet), undated, for Resident						
	#B indicated to transfer Resident #B with						
	two persons and Stand-Up lift.						
	Docidant #D was absenced being						
	Resident #B was observed being transferred from his bed to his wheelchair						
	on 6/14/11 at 11:	11 A.M., with the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155254			LDING	NSTRUCTION 00	C	DATE SURVEY OMPLETED /15/2011		
	PROVIDER OR SUPPLIER	TATION CONVALESCENT CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40 GREENFIELD, IN46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	a Stand-Up lift. side of his bed was ling was secure around his abdorwas positioned it and the rear cast Stand-Up lift slin and Resident #B position. The Stand-Up lift and position. The Stand-Up lift and position was locked and linterview with Colocked the rear colocked and stand-up lift. The positioned in from the was seated or rear lift casters was stand-Up lift slin arms and around Stand-Up lift slin and Resident #B position. The Stand-up lift slin and Resident #B position. The Stand-up and position.	Resident #B sat on the while the Stand-Up lift of under his arms and men. The Stand-Up lift of front of Resident #B ers were locked. The mg was attached to the lift was lifted into a standing and-Up lift rear casters and Resident #B was ositioned in front of his ident #B's wheelchair me was lowered. An ENA #3 indicated she asters on the Stand-Up grandent #B off his bed. Was observed being his bed to his wheelchair eracked and end of his wheelchair eracked and end of his wheelchair eracked and end of his wheelchair eracked end end end end end end end end end e						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPL		
		155254	B. WIN			06/15/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SUGAR	CREEK REHABILITA	ATION CONVALESCENT CENT	ER	1	EST U.S. 40 IFIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ne was lowered. An NA #6 indicated she					
		asters on the Stand-Up					
		Resident #B off his bed.					
	int before ming	resident #B on his oed.					
	An interview wit	h CNA #6 on 6/15/11 at					
		cated the rear caster of a					
		hould be locked when					
	you lifted a resid	ent from a surface and					
	locked when you	are lowering a resident					
	to a surface. CN	A #6 indicated you					
	would leave the l	legs of a mechanical lift					
	in the open or clo	osed position according to					
	the weight of the	resident. CNA #6					
	indicated with a s	small resident you could					
		closed when you lifted					
		sident and if the resident					
	1	ould want to leave the lift					
		ou lifted or lowered the					
	resident.						
	1) Pagidant #C!	s record was reviewed on					
	l ′	M. Diagnosis included,					
		ed to, bilateral lower					
	extremity amputa	·					
	CAUCINITY ampute	MIVII.					
	Resident #C's au	arterly Minimum Data					
	_	, indicated the following:					
		understood and had the					
	ability to underst	and others, his cognitive					
	· ·	, he required total					
		ransfers, he required					
	extensive assistar	nce for bed mobility, and					
	he did not walk.						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155254		B. WING			06/15/2011	
NAME OF I	DROVADED OD GUDDI IEE		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				5430 W	/EST U.S. 40			
SUGAR CREEK REHABILITATION CONVALESCENT CENTER			R		NFIELD, IN46140			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG			1	TAG	DEFICIENCY)		DATE	
		ing assessment for						
		ed 4/18/11, indicated he						
		n assist and required a						
	Hoyer mechanic	al lift for transfers.						
	A gara plan for E	Resident #C indicated						
		s to be transferred with a						
	int to prevent in	ction and shearing.						
	A Resident Care	Record (CNA						
	Assignment She	et), undated, for Resident						
	#C indicated he was to be transferred with							
	2 assist and a mechanical lift.							
	Resident #C was	s observed being						
		the assistance of CNA #3						
		th a Hoyer lift on 6/14/11						
		NA #3 positioned the						
		round the end of the						
	1 '	ked the rear casters. The						
		was fastened to the Hoyer						
	1 '	#C was raised. The						
		oved and Resident #C's						
	wheelchair was moved into positron. Resident #C was lowered into his							
		Hoyer lift rear casters						
	were unlocked and the Hoyer lift was moved away from Resident #C. Resident							
	#C was positioned for comfort. An interview with CNA #3 indicated she had							
		ar casters locked when she						
		C off the stretcher and						
	when she lowere							
	when she lowere	u mm mu ms						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUIL	DING	NSTRUCTION 00	(X3) DATE: COMPL 06/15/2	ETED	
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΝΈ	(X5) COMPLETION DATE	
	An interview with 10:40 A.M., indimechanical lift slatimes when you have surface or lower for the safety of the sa	arterly Minimum Data ated 4/8/11, indicated the dent #D rarely understood stood others, her or daily decision making paired, she required total bed mobility and de did not walk. In assessment for ad 4/1/11, indicated non-weight bearing, she distance, and she required for transfers. The desired the desired of the desir						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			IULTIPLE CO LDING	NSTRUCTION 00	COMPI	LETED			
		155254		IG		06/15/2	:011		
NAME OF PROVIDER OR SUPPLIER			-D	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
SUGAR CREEK REHABILITATION CONVALESCENT CENTER			=K	GREEN	FIELD, IN46140				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	A Resident Care Record (CNA								
	Assignment Sheet), undated, for Resident								
	"	required assistance of 2							
		echanical lift for transfers.							
	Resident #D was	<u> </u>							
		the assistance of CNA #5							
		th the use of a Hoyer lift							
		38 A.M. The Hoyer lift							
		oned under the bed in the							
	closed position. The lift sling was attached to the lift and the rear casters								
		esident #D was lifted and							
		were unlocked. Resident							
	#D was turned to								
		chair was moved into							
		t legs were opened and							
	1 ^	d the wheelchair.							
	1 ^	heelchair was locked and							
		ers were locked. Resident							
		into her wheelchair. The							
	lift rear casters w	vere unlocked and the lift							
		esident #D was positioned							
	*	interview with CNA #5							
	indicated the lift	rear casters were locked							
	when she lifted Resident #D off the bed								
	and when she lov	wered Resident #D into							
	her wheelchair.								
	Δn interview wit	th CNA #5 on 6/15/11 at							
	11:42 A.M., indicated the lift rear casters								
	l '	when you lifted or							
		nt. CNA #5 indicated the							
		e in the closed position							
	int legs should b	- III die eleben poblition							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U11 Facility ID:

000157

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155254		A. BUI	LDING	NSTRUCTION 00	li i	E SURVEY PLETED 2011			
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
	SUMMARY S (EACH DEFICIEN REGULATORY OR when you lift a re position when you chair. CNA #5 in the lift legs in the lowered a resider An observation w at 4:00 P.M., ind fit under Resider position. The owners oper manual for the St LPN #7 on 6/15/ the following: S of the Stand-Up maximum open p handle locked in stability and safe locking the rear s positioning or re- around the patier recommend lock casters of the Sta and transferring a could cause the I patient and assist recommend that left unlocked dur	ATION CONVALESCENT CENTIFICATION CONVALESCENT CENTIFICATION CONVALESCENT CENTIFICATION TO THE PERCEPTION OF THE PERCEPTI		STREET A	EST U.S. 40	ECTION OULD BE	(X5) COMPLETION DATE		
	is initially lifted	e itself when the patient from and transferred to a stationary object.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA		(2) MULTIPLE C			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A	. BUILDING	00		COMPL	
		155254	В.	. WING			06/15/2	J11
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
			5430 WEST U.S. 40					
SUGAR CREEK REHABILITATION CONVALESCENT CENTER			GREE	NFIELD, IN4614	.0			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX			I	PREFIX	CROSS-REFERENC	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		COMPLETION
TAG			ION)	TAG	DE	EFICIENCY)		DATE
	•	ating and maintenance						
		oyer lift provided by						
		11 at 3:15 P.M., indicat	I .					
	_	Varning - Invacare does						
		ocking the rear casters						
	the patient lift wh	hen lifting an individua	1.					
	-	ause the lift to tip and						
	endanger the pati	ient and assistants.						
	Invacare does rec	commend that the rear						
	casters be left un	locked during lifting						
	procedures to allo	ow the patient lift to						
	stabilize itself wh	hen the patient is initial	ly					
	lifted from a chai	ir, bed or any stationary	7					
	object. The legs	of the lift must be in th	ie					
		position and the shifter						
		place for optimum						
	stability and safe							
	successivy with sure	٠,٠						
	The most current	policy and procedure	for					
		novement of residents						
	_	owing: Policy Stateme	ent					
		ect the safety and						
	-	ff and residents, and to						
	_	care, this facility uses						
		niques and devices to li	fi l					
		nts. Policy Interpretation	I .					
		ion - 1.) Resident safet	I .					
	-	•	ıy,					
		and medical condition						
	will be incorporated into goals and decisions regarding the safe lifting and moving of residents 4.) Staff responsible for direct resident care will be							
			.					
			I .					
		e of manual (gait/transfe	er					
	belts, lateral boar	rds) and mechanical						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Even	it ID: KU4	U11 Facility	^{ID} : 000157	If continuation sh	eet Pac	ge 42 of 43

KU4U11 Facility ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED 2011			
NAME OF PROVIDER OR SUPPLIER SUGAR CREEK REHABILITATION CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
IAG	lifting devices					DATE		